MA-2312 MEDICARE PRESCRIPTION DRUG BENEFIT
ISSUED 01/01/06 – CHANGE NO. 03-06

I. INTRODUCTION TO THE MEDICARE MODERNIZATION ACT OF 2003

The Medicare Modernization Act of 2003 provides for prescription drug benefits under Medicare Part D. Medicare beneficiaries must enroll in a Prescription Drug Plan (PDP) to receive these services. Medicaid beneficiaries who are entitled to Medicare Part A and /or enrolled in Medicare Part B will not have prescription drug coverage through Medicaid. Medicaid beneficiaries who are entitled to Medicare must be enrolled in a PDP to have prescription drug coverage, unless there is other prescription drug insurance coverage. Medicaid beneficiaries have no gap in coverage and may or may not have a premium to pay depending on the plan chosen. Medicaid beneficiaries will continue to be responsible to pay co-payments. This includes, but is not limited to, beneficiaries who receive Medicaid through CAP, Work First, State/County Special Assistance, Family and Children's Medicaid, and Aged, Blind and Disabled Medicaid. Institutionalized beneficiaries will not pay a co-payment. Medicaid will continue to pay for other medical services.

Medicaid beneficiaries, entitled to/or enrolled in Medicare, qualify for this Medicare drug coverage. Medicaid beneficiaries, including LTC beneficiaries, may enroll in the plan of their choice and may choose to change plans at anytime. LTC beneficiaries cannot be required to enroll in the PDP the nursing facility requests. Beneficiaries who enroll in a plan other than the basic plan may have to pay a portion of the premium cost. This additional cost cannot be paid by Medicaid and is the responsibility of the enrollee.

Medicaid beneficiaries, entitled to/or enrolled in Medicare, can opt to not be covered by Medicare Part D. This is called affirmatively declining. Medicaid beneficiaries who affirmatively decline Medicare Part D coverage will not be auto-enrolled into a prescription drug plan. Therefore, they will not have prescription drug coverage, unless they have other prescription drug insurance coverage.

Medicaid beneficiariess who affirmatively decline Part D enrollment and do not have other prescription drug insurance coverage, will pay a penalty of 1% of the base benefit premium for each month not enrolled. This penalty will be assessed if the individual chooses to enroll in a Prescription Drug Plan more than 63 days after the loss of Medicaid eligibility.

II. POLICY PRINCIPLES

A. DSS must offer to take an LIS application for any Medicare beneficiary who appears at DSS requesting medical or financial assistance. Refer to MA-2310, Taking the LIS Application.

B. Medicare beneficiaries, not enrolled in a PDP and applying for medical or financial assistance, should be advised to enroll in a PDP as soon as possible to ensure coverage of prescription drug expenses. Refer to X. Other Places to Contact for Medicare Information, below.

C. Medicare beneficiaries do not have prescription drug coverage through Medicaid.

D. Beneficiariess entitled to and/or enrolled in Medicare must be enrolled in a Prescription Drug Plan to receive prescription drug coverage.

E. Excluded Medicare drugs, normally covered by Medicaid, will continue to be covered by Medicaid. Refer to VI. A., Excluded Drugs, below.

F. Non-covered drugs are not covered by Medicaid. These are drugs not listed on the plan's formulary. Refer to VI. B., Non-Covered Drugs, below.

G. Medicare eligibility must be verified in SOLQ, prior to keying the Medicare indicator on the DSS-8125. Refer to EIS-1107, State Online Query/Third Party Query. Keying this indicator sets the Medicaid drug coverage indicator to allow or disallow payment of prescription drugs by Medicaid. Refer to VIII. EIS, below.

H. Do not enter in EIS Medicare eligibility with a start date in the future. Wait until the month prior to the Medicare eligibility start date to key the Medicare eligibility date into EIS. Keying Medicare entitlement earlier than the month prior to the Medicare start date will result in the having no prescription drug coverage through Medicaid or Medicare. Refer to VIII. EIS, below.

I. Medicaid beneficiariess receive timely notice when Medicaid will no longer cover prescription drugs. These notices will be generated by EIS in some situations and must be completed by the county caseworker in others. Refer to EIS 3520, Medicare Entitlement and Enrollment. Refer to IX. Notices and Appeals.

J. Pharmacies have the right to refuse services if the Part D co-payment is not paid to the pharmacy.

K. Individuals entitled to or enrolled in Medicare Parts A and/or B, not enrolled in a PDP, who apply for Medicaid are ineligible for prescription coverage from Medicaid. This includes the retro and ongoing months. Coverage for prescription drugs for Medicare beneficiaries will only be covered through a Medicare Part D Prescription Plan or other private insurance.

III. ENROLLMENT

All Medicare beneficiaries, including those receiving Medicaid, can choose to enroll in a PDP upon entitlement to Medicare. Medicaid beneficiaries entitled to Medicare, including individuals eligible for the Medicare Savings Plans (MQB-Q, B, & E), may choose to change plans at anytime.

Enrollment in a PDP provides prescription drug coverage. If Medicaid beneficiaries entitled to/or enrolled in Medicare, affirmatively decline Medicare Part D, have no other prescription drug insurance coverage, or fail to enroll in a PDP, they will not have prescription drug coverage.

Medicaid beneficiaries entitled to Medicare and not enrolled in a PDP will be automatically enrolled in a PDP by the Centers for Medicare and Medicaid Services (CMS). The purpose of this auto-enrollment is to ensure prescription drug coverage for Medicaid individuals entitled to Medicare.

Beneficiaries receiving Medicaid and entitled to Medicare will be identified through a system of data exchanges. Data will be exchanged between the Division of Medical Assistance (DMA) and CMS. Part of this exchange process will include:

- Identifying Medicaid beneficiaries entitled to/or enrolled in Medicare
- Updating the EIS Medicare Data screens
- CMS enrolling beneficiaries into a PDP, if not previously enrolled
- EIS generating a notice to the newly identified Medicare/Medicaid beneficiaries regarding the change in Medicaid benefits

All Medicaid beneficiaries receiving Medicare and all Medicare beneficiaries who become Medicaid eligible will be enrolled through this process, unless enrollment in a PDP already exists. Beneficiaries who affirmatively decline Part D will not be enrolled, and will be coded in EIS as entitled to Medicare, which will prevent Medicaid from covering prescriptions. Therefore, beneficiaries who affirmatively decline Medicare Part D will not have prescription drug coverage, unless they have other prescription drug insurance coverage.

The process of identifying beneficiaries, updating EIS, enrolling in a PDP, and generating a notice will take at least two months. Until the process is complete and enrollment is finalized, newly eligible Medicaid beneficiaries who did not previously enroll in a Prescription Drug Plan will not have drug coverage through Medicaid. For this reason, applicants not enrolled in a PDP and without other prescription drug insurance coverage, must be advised to enroll in a PDP. Individuals can enroll directly with the PDP of their choice, or seek the help of Medicare or the North Carolina Seniors' Health Insurance Information Program. Individuals who enroll while Medicaid eligibility is being determined will avoid further delay of prescription drug coverage. Refer to X., Other Places to Contact for Medicare Information, below.

A. Data Flow for Enrollment Process

Flow of data for enrollment in LIS and Part D for a beneficiary with Medicaid coverage who is entitled to or enrolled in Medicare Part A and/or B:

1. When an individual is approved for Medicaid (Adult or Family and Children's), Work First, CAP, or SA and is entitled to Medicare, he is eligible for the State to pay the Medicare Part B premium through buy-in. A file of beneficiariess who are eligible for buy-in is sent each month to CMS.

2. When a beneficiary is on buy-in or we are attempting to accrete him to buy-in, he is included on the MMA file the State sends to CMS twice each month. Federal policy requires each state to send to CMS this file of beneficiaries who have both Medicaid and Medicare coverage

3. CMS does a match of the information the State submitted on the MMA Data file with information on Medicare records. CMS returns information to the State within 48 hours about Medicare A, B, C, (Part C is Medicare Advantage) and D and also identifies beneficiaries who did not match the Medicare records. This is called the MMA Response file.

4. If a beneficiary on the MMA Response file is entitled to Medicare Part D and is not enrolled with a PDP, CMS will automatically enroll him with a PDP by the middle of the next month.

5. The Medicare A, B, C, and D information from the MMA Response file is added to the Medicare A/B/C and D screens in EIS at the end of each month.

   EXAMPLE: A Medicare beneficiary previously eligible for Part D, but not enrolled in a PDP is approved on January 20th for Medicaid. Worker keys "y" for Medicare A and/or B on the DSS-8125 approval. The beneficiary is included on the February buy-in file and is included on the February MMA file. The MMA Response file is returned to the State within 48 hours and is loaded to EIS at the end of February. If the beneficiary is a match with CMS data, the MMA Response file will include the beneficiaries Medicare A, B, C, and D information. However, the MMA Response file does not include the plan the beneficiary is auto enrolled in. CMS automatically enrolls the beneficiary in a PDP and sends the beneficiary the PDP information around the middle of March. The plan information is included in the March MMA Response file and is loaded to EIS the end of March.

6. Beneficiariess that do not match CMS data are returned to the State on an error report. These errors will be reconciled by the State Claims Analysis Unit.

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B. Medicare beneficiaries who become Medicaid eligible

1. Usually Medicare beneficiaries who become Medicaid eligible and are not already enrolled in a PDP will be automatically enrolled by CMS the month following the month the beneficiary is included on the buy-in file. If there is a non-match with CMS data, the enrollment is delayed until the non-match is resolved. The following list includes, but is not limited to, beneficiaries who will be automatically enrolled:

    a. Beneficiaries with creditable coverage;

    b. CAP beneficiaries;

    c. Beneficiaries receiving Medicaid through State/County Special Assistance

    d. Beneficiaries receiving Medicaid through Work First

    e. Beneficiaries in Family and Children's Medicaid

    f. Beneficiaries in Aged, Blind and Disabled Medicaid, including private living arrangement and long-term care.

    These beneficiaries will not have prescription drug coverage until the enrollment is complete. However, applicants not enrolled in a PDP and without other drug coverage insurance should be advised to enroll in a PDP while Medicaid eligibility is being determined. The county worker should also complete the LIS application during the initial interview. Refer to MA-2310, Taking the LIS Application.

2. Prescription drug expenses cannot be paid or reimbursed by Medicaid. Excluded drugs may be billed to Medicaid. Refer to VI. A. Excluded Drugs, below.

C. Medicaid beneficiaries who become eligible for Medicare

Medicaid beneficiaries who become entitled to Medicare will be automatically enrolled in a PDP. Coverage by the PDP will be retroactive to the month of Medicare eligibility, except when retroactive eligibility for Medicare Parts A and/or B is determined. Eligibility for Medicare D is effective the first day of the month in which the beneficiary received notification of retroactive Medicare A/B entitlement. Medicare Part D entitlement cannot be retroactive.

Example: On July 1, 2006, SSA determines an individual disabled effective January 1, 2004, and entitled to Medicare January 1, 2006. Notification of SSA and Medicare eligibility is sent to the individual July 1, 2006. This individual is eligible for Medicare D effective July 1, 2006. An existing Medicaid beneficiary would be enrolled in a plan effective July 1, 2006. A non-Medicaid individual would not be enrolled until the month after he/she requests enrollment with a plan.

IV. OTHER PROGRAM AREAS

A. Deductible Cases and Unmet Medical Needs

Drug expenses paid by the PDP or other insurance cannot be applied to the deductible or used as an unmet medical need in long term budgeting. However, under certain circumstances expenses not paid by the PDP or other insurance may be applied to the deductible or used as an unmet medical need to reduce the PML.

Prescription drug expenses can only be used to meet the deductible or reduce the PML when:

1. The Medicare beneficiary was not enrolled in a PDP, there was no other prescription drug coverage on the date of service, and the individual **did not affirmatively decline** enrollment in Medicare Part D, or

2. The Medicare beneficiary was enrolled in a PDP or had other prescription drug coverage on the date of service and provides verification, such as an explanation of benefits, from the PDP or other insurer identifying the expense as a beneficiary deductible, co-pay, or due to the donut hole, or

3. The Medicare beneficiary provides a statement from the PDP or other insurer that the drug is a non-covered drug **and** the beneficiary requested an exception and the exception was denied.

   If a drug appears on an explanation of benefits and no exception has been filed, do not allow the expense to be applied to the deductible or to reduce the PML.

B. CAP Cases

CAP beneficiaries, without other prescription drug coverage and entitled to Medicare, must also enroll in a PDP to have prescription drug coverage. CAP beneficiaries without other insurance may affirmatively decline enrollment in a PDP. However, these costs will not be paid by Medicaid and **can not be applied to the deductible**. The CAP beneficiary will NOT have prescription drug coverage.

CAP beneficiaries enrolled in a PDP will also be required to pay a co-payment. Co-payments may be applied to the deductible.

Due to drug costs being paid by the PDP, CAP beneficiaries may not have enough drug expenses to meet the deductible. CAP beneficiaries may need to incur or pay other medical expenses to become eligible on a monthly basis.

C. Transportation

The county must provide transportation or reimburse for transportation expenses related to obtaining prescription drugs in accordance with the transportation policy. This includes transportation for full benefit Medicaid beneficiaries entitled to/or enrolled in Medicare. Refer to MA-2910, Medicaid Transportation and county transportation policy for additional requirements. The county is not responsible to determine whether Medicaid or the Medicare PDP will be covering the prescription costs when providing transportation.

D. Food Stamps

Food stamps offset income with medical expenses over a certain limit. Expenditures for drugs will decrease with the Medicare drug benefit. This will have a direct impact on food stamp benefit amounts. Benefit amounts will decrease as medical expenses decrease.

V. OTHER DRUG COVERAGE

A. Creditable Coverage

1. Other insurance coverage that provides at least the same or better prescription coverage as Medicare Part D is considered creditable coverage. Individuals with third party insurance benefits will receive annual notification from the insurance company advising if current insurance coverage is creditable. This letter may also contain other options available to the member. The following are examples of creditable coverage:

    a. Medicare Advantage (Part C) with prescription drug coverage,

    b. Employer or union based health benefits with prescription drug coverage,

    c. TRICARE, VA, and federal employee health benefits.

Medicaid beneficiaries with creditable coverage will be auto-enrolled into a prescription drug plan, but may not need to continue enrollment in a PDP. Auto-enrolled individuals with creditable coverage will need to contact the Prescription Drug Plan to request to be disenrolled if applicable. In addition, these beneficiaries will also need to contact Medicare to affirmatively decline PDP enrollment. (Beneficiaries who do not affirmatively decline will continue to be automatically enrolled.)

2. Not all third party insurance is considered creditable coverage. The following are excluded and would not be considered creditable coverage:

   a. Medicare Advantage (Part C) without prescription coverage

   b. Medigap policies

   c. Insurance that only covers certain conditions or diseases

3. Individuals with drug coverage insurance that is not creditable coverage can:

   a. Keep the current drug plan and join a prescription drug plan, or

   b. Drop the current drug plan and join a prescription drug plan, (However, if dropped the individual may not be able to get this coverage back in the future.), or

   c. Keep current drug plan and choose not to enroll in a prescription drug plan. Individuals who choose not to enroll in a prescription drug plan and have no creditable coverage will pay a penalty if enrollment is processed at a later date. Penalty is 1% of the base benefit premium for each month not enrolled in a PDP.

B. VA Benefits

Veteran's benefits are considered creditable coverage. A veteran must be enrolled in VA benefits to have coverage. Individuals enrolled in VA benefits may choose not to enroll in a PDP. However, individuals who are not enrolled in the VA benefit and do not enroll in a Medicare Part D prescription drug plan when eligible, will be subject to the penalty for late Medicare D enrollment. There are some instances when a VA enrolled individual may benefit from enrolling in a Medicare PDP and they are:

1. VA person is in a nursing home that does not accept VA.

2. VA facility is not conveniently located for the individual.

3. VA person wants to fill prescriptions at a local pharmacy.

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C. TRICARE Benefits

TRICARE is considered creditable coverage. Individuals covered by TRICARE have comprehensive pharmacy coverage with no monthly premium and minimal co-payments. TRICARE beneficiaries can choose to enroll in a Medicare Prescription Drug Plan. However, no penalty is added if Medicare Part D enrollment is requested at a later date.

D. Employer or Union Based Insurance

Medicaid beneficiaries with employer or union based prescription coverage that is considered creditable coverage will be auto enrolled into a Medicare Prescription Drug Plan.

Medicaid beneficiaries with employer or union based prescription coverage that is not creditable coverage can:

1. Keep the current drug plan and join a prescription drug plan, or

2. Drop the current drug plan and join a prescription drug plan, (However, if dropped the individual may not be able to get this coverage back in the future.) or

3. Keep current drug plan and choose not to enroll in a prescription drug plan. Individuals who choose not to enroll in a prescription drug plan and have no creditable coverage will pay a penalty if enrollment is processed at a later date. Penalty is 1% of the base benefit premium for each month not enrolled in a PDP.

VI. EXCLUDED AND NON COVERED-DRUGS

A. Excluded Drugs

An excluded drug is a class of drugs not required to be covered by the PDP. However, some PDPs may choose to cover these drugs. Some categories of excluded drugs, not covered by the plan, will be covered by Medicaid. Excluded drug costs paid or incurred by a beneficiary may also be applied to the deductible. Medicaid will cover the following excluded drug classes;

1. Agents used for the symptomatic relief of cough and colds,

2. Prescription vitamins and mineral products, except prenatal vitamins and fluoride,

3. Barbiturates,

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4. Benzodiazepines, and

5. Nonprescription drugs under NC DMA General Clinical Policy A2

B. Non-Covered Drugs

A non-covered drug is a drug not included in the plan's formulary and has failed to be approved through the appeal process. These drugs are not covered by Medicaid; however, some expense for non-covered drugs may be applied to the deductible or used as an unmet medical need to reduce the PML. Refer to IV.A. above. Individuals can and should request these drugs be covered by the PDP through an appeal with the plan. Plans are required to cover these drugs during the appeal process. Individuals should contact the plan for information on how to appeal.

VII. MEDICAID ID CARD

Medicaid beneficiaries with Medicare receive yearly Medicaid ID cards. The Medicaid cards are gray in color and must be presented to the provider along with the Medicare card at each time services are requested. Beneficiaries enrolled in a Medicare Part D plan must present their Part D plan card at each visit to the pharmacy.

VIII. EIS

Individuals entitled or enrolled in Medicare Part A and/or B will be identified through the Medicare information in EIS. This information may be keyed at the county or automatically entered through the MMA Response file. Refer to EIS 3520, Medicare Entitlement and Enrollment for additional information.

A. Entering Information in EIS

Medicaid beneficiaries identified by EIS as being entitled to or enrolled in Medicare A and/or Medicare B on the initial DSS-8125 will not have Medicaid prescription coverage.

The Medicare A and Medicare B fields on the DSS-8125 identify if a beneficiary has Medicare. This field also sets the Medicaid drug coverage indicator on the Medicare D data screen. When a "Y" is entered in either the Medicare A and/or Medicare B field, Medicaid will no longer pay for prescription drugs. To avoid errors resulting in claims being denied or paid incorrectly, the county caseworker must:

1. Verify Medicare Part A and/or Part B entitlement/enrollment in SOLQ before keying the "Y" on the DSS-8125.

2. Key the DSS-8125 no earlier than the month preceding the Medicare entitlement start date for both Part A and/or Part B. Keying Medicare entitlement earlier than the month prior to the Medicare start date will result in Medicaid no longer paying for prescriptions the next month.

   a. Initial approvals with Medicare entitlement dates in the future, even the next month, should be keyed as an "N", and then changed to a "Y" the month preceding the Medicare entitlement.

      Example: The case is approved July 1, 2006. Medicare entitlement begins September 1, 2006. Key the July 1 approval with an "N" indicator. At the first of August change the "N" to "Y".

   b. Initial approvals with Medicare effective dates after the application date, but prior to the case approval date should be keyed as a "Y".

      If the beneficiary has paid prescription drug expenses prior to the Medicare entitlement date **and** the provider is willing to reimburse the expenses contact DMA Claims Analysis Unit to have indicator corrected for the month(s) the individual did not have Medicare.

      Example: A/B applies June 21, 2006. Medicare entitlement begins July 1, 2006. Approval is keyed July 24, with an effective date of June 1, 2006. Key the approval with a "Y" indicator. If the a/b has paid prescription expenses in June and the pharmacy is willing to bill Medicaid for these June expenses, the indicator will need to be changed by the Claims Analysis Unit. Follow procedures in number 3. below.

3. Medicare A and Medicare B indicators set to "Y" incorrectly will not allow Medicaid payment for prescription drugs. Counties must contact the DMA Claims Analysis Unit to correct the indicator. Refer to EIS 1200, State Office Contacts.

B. Data Screens

Two Medicare data screens are available through EIS. For information on these screens refer to EIS 1054, Individual Inquiry.

1. Medicare A/B/C Entitlement Data

   The Medicare A/B/C Entitlement Data screen indicates when a beneficiaries entitlement to Medicare began and/or ended. Information displayed on this screen is a result of the MMA Response file, and/or by the county caseworker keying "Medicare" indicators on the DSS-8125.

A "Y" or a "Z" next to the Medicare field indicates this individual has Medicare and is not entitled to Medicaid drug coverage. The "Y and Z" also change the Medicaid Drug Coverage indicator on the Medicare D screen in EIS to "N", indicating Medicaid will not pay for prescription drugs.

2. Medicare D Data

The Medicare D Data screen identifies the following:

a. Begin and end date of Medicare Part D entitlement

b. Begin and end date of Plan enrollment

c. PDP and Medicare Advantage Plan identification numbers (See the Department of Insurance SHIIP web site http://www.ncdoi.com/SHIIP/Medicare/shiip_part_d.asp for Stand-Alone Prescription Drug Plans and http://www.ncdoi.com/SHIIP/Medicare/shiip_advantage.asp Medicare Advantage Plans, for the plan names associated with the plan numbers.)

d. Type of enrollment

(1) Auto-enrollment

(2) Beneficiary choice

(3) Affirmatively declined

(4) Facilitated (Enrollment of LIS, non-Medicaid individuals)

e. Date notice of action was sent to Medicaid individual by EIS

f. Medicaid drug coverage for Medicare beneficiaries and the effective date

(1) "N" in this field indicates Medicaid is NOT paying for prescription drugs.

(2) "Y" in this field indicates Medicaid is paying.

g. EIS/DMA/MMA indicates who updated the Medicare information.

h. The date the information was added to the screen.

IX. NOTICES AND APPEALS

A. Automated and Manual Notices

A beneficiary who is no longer entitled to have Medicaid to pay for prescription drugs must receive a notice. Refer to EIS 4000, Codes Appendix B

(IX. A)

1. Medicare beneficiaries approved for Medicaid, including SSI beneficiaries, will be notified on their approval notice that Medicare is responsible for prescriptions.

2. For caseworker actions on the DSS-8125 where Medicare A and/or Medicare B is changed to Y, and the caseworker is completing some other adverse action and has a timely notice code, EIS adds the following to the automated notice:

   "Now that you are enrolled/receiving Medicare, Medicaid will not pay for your prescriptions. Medicare is responsible for your prescriptions."

B. System Generated Notices

Medicaid beneficiaries must receive at least an adequate notice when their benefits change due to a change in Medicare entitlement. In some situations, the system has been programmed to generate notification automatically. Notices will be produced when the following occurs:

1. DMA-MMAT Notice notifies Medicaid beneficiaries that Medicaid will no longer pay for prescriptions, now that he/she is enrolled/receiving Medicare. This notice will be sent to the Medicaid beneficiary when the Medicare A and/or Medicare B indicator changes from an "N" to a "Z" or "Y". This change of indicator may result from a DSS-8125 keyed with a timely notice code by the caseworker or from EIS as a result of the MMA Response file.

2. DMA-MMAA Notice is an adequate notice. This notifies the Medicaid beneficiary that Medicaid will now pay for prescriptions because he/she is no longer enrolled/receiving Medicare. This notice will be sent to the Medicaid beneficiary when the Medicare A and/or Medicare B indicator is changed from a Y or Z to an N. This change of indicator can only result when EIS processes data from the MMA Response file.

C. Appeals

This change was a result of federal law. An appeal is not allowed unless the reason for the appeal is incorrect computation or a discrepancy with Medicare entitlement.

X. OTHER PLACES TO CONTACT FOR MEDICARE INFORMATION

Information for Medicare Part D may be obtained from CMS and North Carolina Seniors' Health Insurance Information Program (SHIIP). CMS is responsible for administering the Medicare program and is responsible for quality standards in health care. SHIIP is responsible to assist Medicare beneficiaries in choosing a plan. Below is the contact information.

Centers for Medicare and Medicaid Services
1-800-MEDICARE 1-800-633-4227
www.medicare.gov

North Carolina Seniors' Health Insurance Information Program
1-800-443-9354
www.ncshiip.com